

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13674

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gordon</b> Middle <b>Matthew</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>10</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-67</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Calvert County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Claude Brooks, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Celeste Virginia Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Celeste Brooks</b>		Address <b>Huntingtown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Baby</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 Pound 3 oz.</b> DUE TO (c) <b>305.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 'p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1</b> , 19 <b>67</b> , to <b>Oct. 2</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Oct. 2</b> , 1967, and that death occurred at <b>12:00 noon</b> from causes and on the date stated above.			
22a. SIGNATURE <b>D. Wallis</b>		22b. DATE SIGNED <b>10-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Issam F. el Damalouji, M.D.</b>		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-2-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cryptotown</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Frederick, Md.</b>	
24. FUNERAL DIRECTOR <b>Claude Brooks Jr</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13671

13675

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.B.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Hts Md</u>	
c. LENGTH OF STAY IN 1b <u>Transient</u>		d. STREET ADDRESS <u>2479 Rochelle Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JEFFERY Lee Bylan</u>		4. DATE OF DEATH <u>10 15 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographic Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Bylan</u>		14. MOTHER'S MAIDEN NAME <u>Viola M. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes. --</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Joseph Bylan-Same as Item #2.</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> DUE TO <u>suicidal wound of head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found in yard at NB Md</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Port II of item 18.) <u>suicidal wound of head</u>	
20c. TIME OF INJURY Month, Day, Year <u>2300 10 15 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N. Beach</u>	20f. (City or town) <u>Cal.</u> (County) <u>Md</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		22. DATE SIGNED <u>10/15/67</u>	
EXAMINER'S NAME (Type) <u>Hugh W. Ward, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>---</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem:</u>	23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
 Item #2 Film #G394 11/3/67 ph

13672

**CERTIFICATE OF DEATH**

13676

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>			c. LENGTH OF STAY IN 1b <b>180 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Irene</b> Last <b>Eagons</b>				4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-08</b>		9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Ernest Offer</b>				14. MOTHER'S MAIDEN NAME <b>Victoria Freeland</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-34-4933</b>		17. INFORMANT Address <b>Hospital Medical Record</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>260X</b> DUE TO <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Diabetes Mellitus</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/67</b> , 19__, to <b>10/15/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>10/15/67</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>R de VILLARREAL MS</b>				22d. ADDRESS <b>St Leonard</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>10-19-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Ch. CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>Barstow Calv. Md</b>		
24. FUNERAL DIRECTOR ADDRESS <b>P.E. Sewell Prince Fred, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 17 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13673

CERTIFICATE OF DEATH

13677

1. PLACE OF DEATH o. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>16 1/2 hrs.</b>				d. STREET ADDRESS <b>632 Deepdene</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Meyers</b>				4. DATE OF DEATH Month Day Year <b>10 26 19 67</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-25-67</b>		9. AGE (In years last birthday) Yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Calvert, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Caldwell Donald Meyers</b>				14. MOTHER'S MAIDEN NAME <b>Carol Lee Chesney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Carol Lee Meyers</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7730 Cyanin (undetermined)</b> DUE TO (b) <b>Hyaline membranes of lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 25</b> , 19 <b>67</b> , to <b>Oct. 26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct. 26</b> , 19 <b>67</b> , and that death occurred at <b>7:15aM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Roberto de Villarreal, M.D.</b>				22d. ADDRESS <b>St. Leonard, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10-30-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvert County Hosp. Prince Frederick</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Helen P. Truvellos, Administrator</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 31 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

7-040610







MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13674

13678

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Calvert</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b> c. LENGTH OF STAY IN 1b <b>37 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b> d. STREET ADDRESS <b>Pond 5209 Deer Park Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ellis</b> Middle <b>Neal</b> Last <b>Perry</b>			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>22</b> Year <b>19 67</b>								
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <b>6-27-24</b>		<b>9. AGE</b> (In years lost birthday) <b>43</b> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Barber</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Washington, D.C.</b>								
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S.A.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>								
<b>13. FATHER'S NAME</b> <b>Ellis N. Perry, Sr.</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>K. Sydnor</b>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>5209 Deer Park Lane</b>								
<b>17. INFORMANT</b> <b>Margaret E. Perry, Washington, D. C.</b>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Disease</b> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>						
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)							
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>8/7</b> , 19 <b>66</b> , to <b>10/22</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>10-21</b> 19 <b>67</b> , and that death occurred at <b>11:30 AM</b> , from causes on and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Osman Z. Ersoy, M.D.</b>			<b>22b. DATE SIGNED</b> <b>10/22/67</b>								
<b>22c. PHYSICIAN'S NAME (Type)</b>			<b>22d. ADDRESS</b> <b>Prince Frederick, Maryland</b>								
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>10/25/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Barnabas Cemetery</b>							
<b>23d. LOCATION (City or Town)</b> (County) (State) <b>Oxon Hill, Maryland P.G.</b>		<b>24. FUNERAL DIRECTOR</b> <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>									
<b>25a. REC'D BY REGISTRAR</b> <b>DATE OCT 24 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

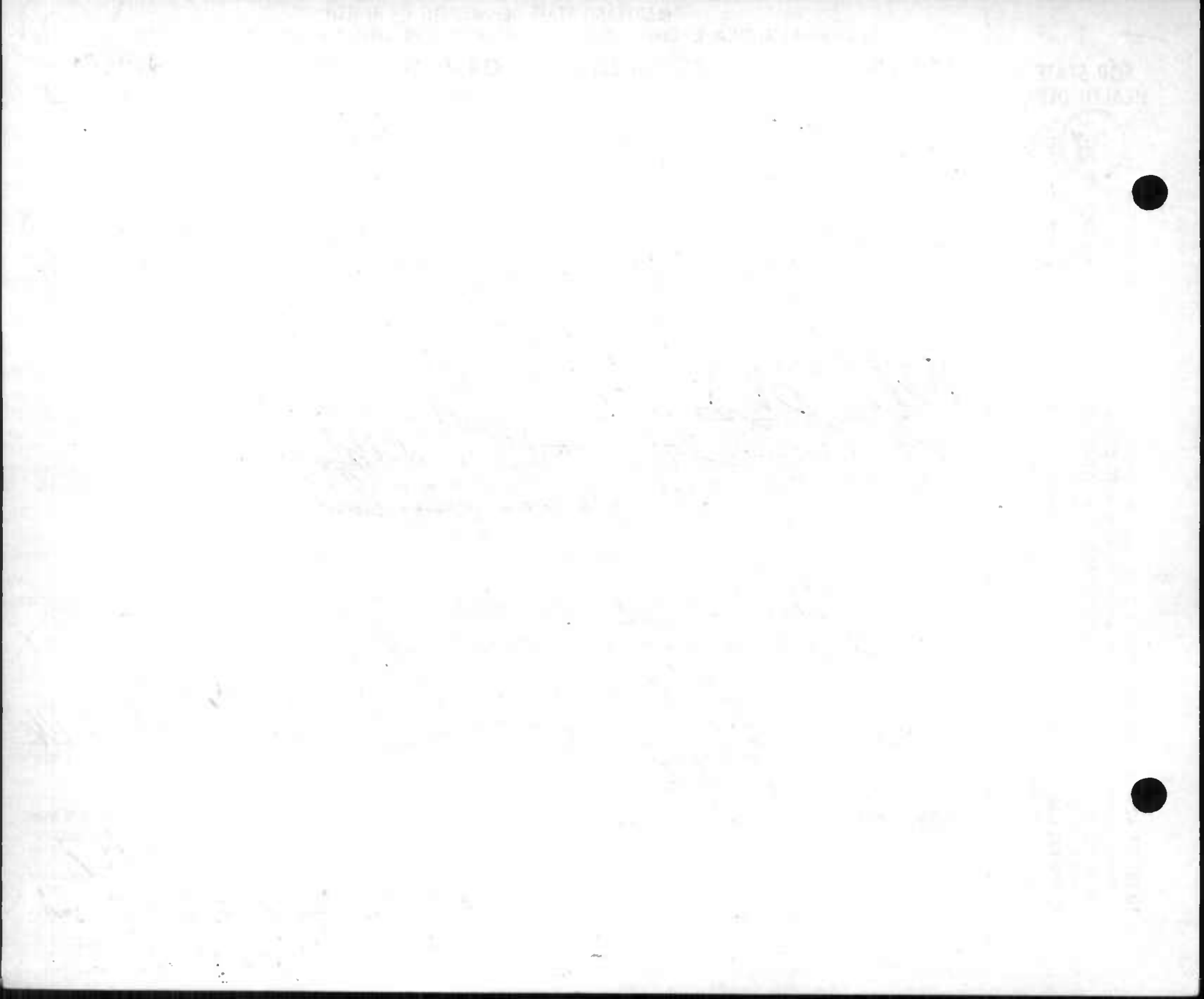
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-13. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Leon Belmer Smith Jr</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/1919</u>
9. AGE (In years last birthday) <u>48</u> Yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leon D. Smith Sr</u>		14. MOTHER'S MAIDEN NAME <u>Mora Dean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or went down) <u>Army</u>		16. SOCIAL SECURITY NO. <u>245-15-9601</u>	
17. INFORMANT <u>Mr. Edith Smith</u>		Address <u>N. Beach Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Had been treated for a heart ailment</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in bed at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>530 a.m. 10 16 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>N. Beach</u> (County) <u>Calvert</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u>		22. DATE SIGNED <u>10/16/67</u>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		M.D.	
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 18, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>So Memorial Garden</u>	23d. LOCATION (City or Town) <u>Bunkirk</u> (County) <u>Calvert</u> (State) <u>MD</u>
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Divings, Md</u>		DATE <u>OCT 18 1967</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

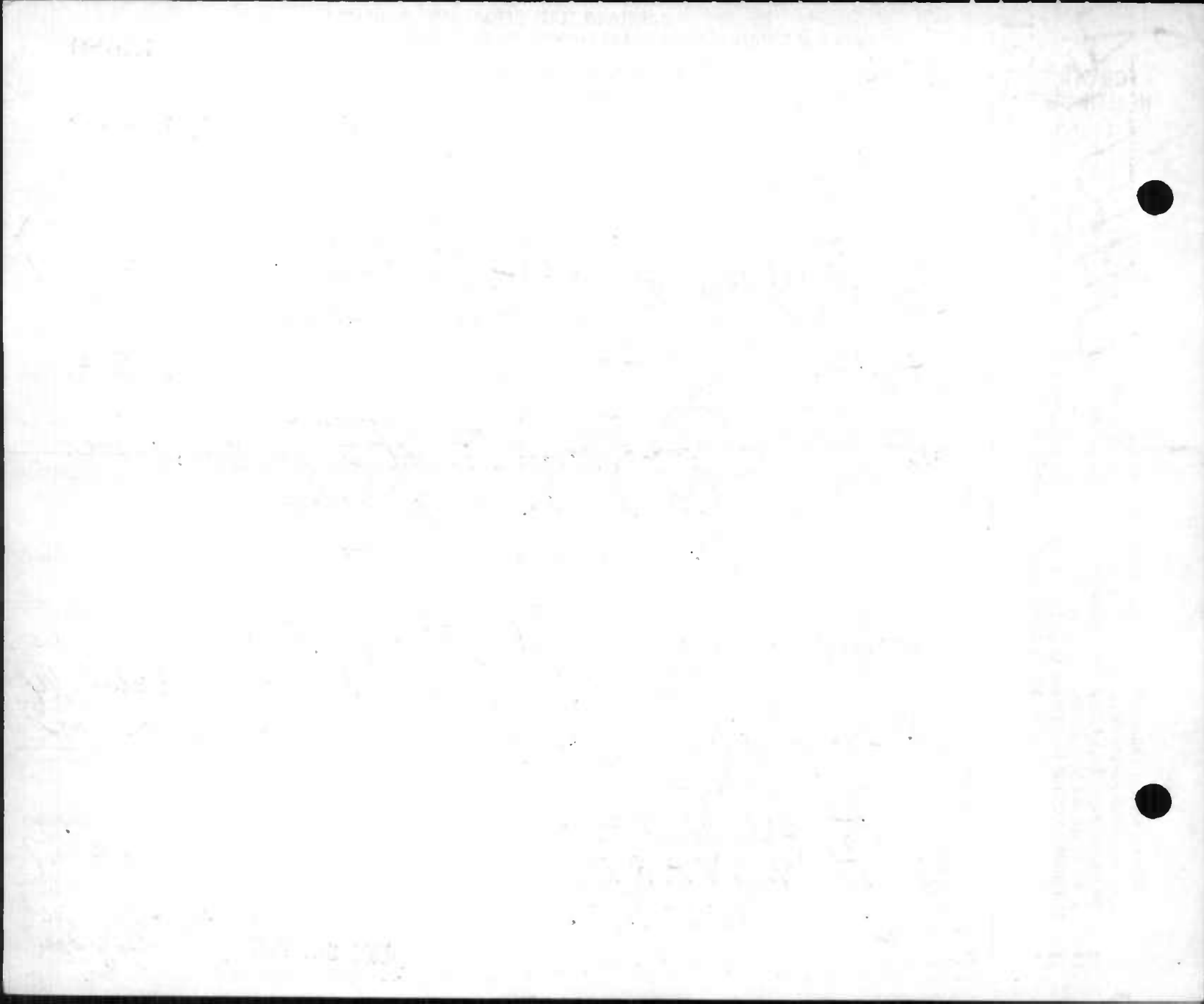
FOR STATE  
HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Waldred Elizabeth Steele</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>
13. FATHER'S NAME <u>—</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-20-9340</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crossing river</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed at 9:40 AM</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in bed</u>		
20c. TIME OF INJURY Month, Day, Year <u>9:30 a.m. 10 23 1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>N. Beach</u> (County) <u>Calvert</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) <u>H. W. WARD</u>		22. DATE SIGNED <u>10/23/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>So. Memorial Gardens</u>	23d. LOCATION (City or Town) <u>Dunkirk</u> (County) <u>Calvert</u> (State) <u>MD</u>
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 26 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Calvert</i> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>St. Leonard</i> c. LENGTH OF STAY IN ID <i>years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>St. Leonard (rural)</i> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <i>Thomas Ammon Woolford</i> First Middle Last <b>5. SEX</b> <i>M</i> <b>6. COLOR OR RACE</b> <i>W.</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <i>WIDOWED</i> <input type="checkbox"/> <i>DIVORCED</i> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>June 3 1896</i> <b>9. AGE</b> (In years last birthday) <i>71</i> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.						<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Waterman</i> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Dorchester Co., Md.</i> <b>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> </b>					
<b>13. FATHER'S NAME</b> <i>Thomas Milborne Woolford</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Bertie Abramson</i>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>Yes</i> <i>W.W.I</i> <b>16. SOCIAL SECURITY NO.</b> <i>216-18-5861</i> <b>17. INFORMANT</b> <i>Marguerite Woolford</i> Address <i>St. Leonard, Md.</i>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 4201 DUE TO (b) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <i>19</i> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> (County) (State) _____											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> _____, 19____, <b>to</b> <i>10/5/67</i> , <b>that (I) (we) last saw the deceased alive on</b> _____, 19____, <b>and that death occurred at</b> _____ M, <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>[Signature]</i> <b>22b. DATE SIGNED</b> <i>10/5/67</i> <b>22c. PHYSICIAN'S NAME</b> (Type) <i>R. De Villard</i> <b>22d. ADDRESS</b> <i>St. Leonard, Md.</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i> <b>23b. DATE THEREOF</b> <i>Oct. 13, 1967</i> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>St. Paul's Meth. Cemetery</i> <b>23d. LOCATION</b> (City, town, or county) (State) <i>Lusby Calvert Co., Md.</i>											
<b>24. FUNERAL DIRECTOR</b> <i>A. A. Harkness &amp; Son</i> <b>25a. REC'D BY REGISTRAR</b> <i>[Signature]</i> <b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i> <b>DATE</b> <i>OCT 13 1967</i>											



PRICE